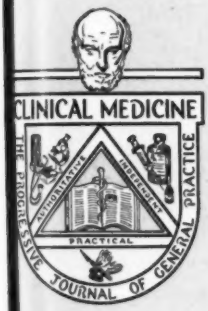
CLINICAL MEDICINE



LEADING ARTICLES

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MARCH 1944

VOLUME 51 NUMBER 3

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VOLUME 51 MARCH, 1944 NUMBER 3

A Simple Method for Localization of Foreign Bodies

By LEWIS GREGORY COLE, M.D., *White Plains, New York*

THIS is a simple, accurate method of localizing and extracting foreign bodies.

The relationship of a foreign body to a point on the surface and how deep it lies beneath the surface may be determined accurately by mathematics (see Fig. 4). This procedure, as well as a description of a simple slide rule square, was described by the author previously.[1]

In this procedure, roentgenologic calipers and surgical calipers are used as companion units (see Figs. 1 and 2). A gadget for accurately marking the exact center of the lower ring (R in Fig. 1) of the roentgenologic calipers is most important.

The block tin (FP in Fig. 2) with a hole in the center through which the surgical pointer is inserted, is important to help the surgeon reorient himself if the incision has eliminated one of the markers.

The sighting device of the roentgenologist's caliper, similar to that on a gun, is mathematically accurate, subject only to human errors, that are in proportion to the accuracy with which the instrument is used.

Roentgenologic procedure.

1. The size, shape, and number of foreign bodies are determined by fluoroscopic examination.

2. The tube is placed below the part so that the central ray passes vertically through the foreign body. This is accomplished by closing the diaphragm until the illuminated area on the screen is approximately the size of the foreign body, and the foreign body appears in the center of the illuminated area.

3. Without moving the tube or the part,

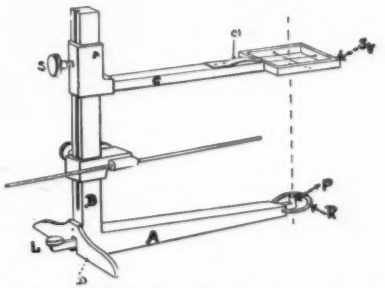


Fig. 1. Roentgenologist's Caliper. A—lower horizontal arm, R—lower sighting ring, P—plunger in center of ring, L—lever activating plunger, B—vertical rod, C—upper horizontal arm, Sq—Cross wire sighting square.

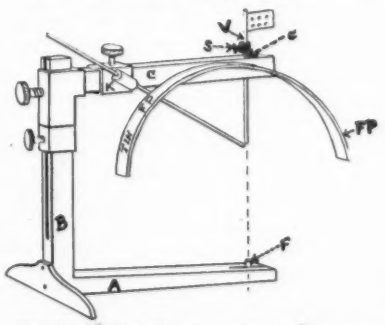


Fig. 2. Surgical Caliper. A—lower horizontal arm, F—pin (corresponding to P of Fig. 1), B—vertical rod, C—upper horizonal arm, G—small hole for indicator, V—indicating rod, S—stop on indicating rod, FP—unattached blocked tin (profondometer) used with both calipers.

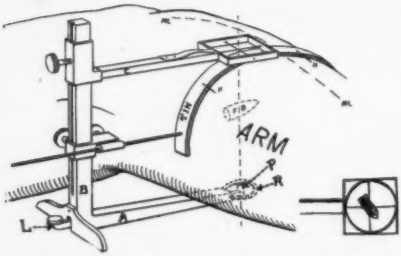


Fig. 3. Application of the Roentgenologist's Caliper to a foreign body in the arm. (Inset) Sighting device; appearance when on its target.

open the diaphragm and place the lower horizontal arm (A) so that the ring (R) perfectly encircles the foreign body. (See Fig. 1 or 3)

4. Place the upper horizontal arm (C) on the vertical rod (B) so that the cross wires coincide with the ring, giving the image as shown in figure 3 (Inset). If the ring and the cross wires do not coincide, the tube is not centered in the box beneath the diaphragm and should be readjusted.

5. Press the lever (L); this causes a plunger (P) in the center of the ring to mark a point on the posterior surface directly beneath the foreign body. Then mark the skin beneath the cross wires of the upper sight with indelible pencil.

6. Insert a film or paper beneath the clamp on the upper arm and make an exposure. Then shift the tube in the longitudinal direction of the table 15 centimeters from the vertical ray, and make a second exposure on the same film without moving the film or the part.

7. Place the blocked tin (profondometer) so that it encircles the upper surface of the part, and the small hole is at the center of the cross wires.

8. Develop the film and measure the distance between similar points on the two images; this indicates the shadow shift. Now the depth of the foreign body may be determined accurately by constructing a geometric figure and mathematical calculation. (See Fig. 4).

Surgical Procedure

The surgical caliper is readily disassembled into several parts, particularly an upper horizontal arm and a lower. The entire caliper should be sterilized, but the lower arm may not remain sterile, while the upper arm and indicating rod must remain so.

1. Place the lower horizontal arm (see Fig. 2) of the surgical caliper under the part in such a position that the pin (F) on its distal end engages in a hole of a washer or glove clasp.

2. Adjust the patient in approximately the same position he was in when the localization was made.

3. Place the upper horizontal arm (C) in position with its undersurface resting on the skin. Then adjust the patient without moving the lower horizontal arm until the center of the cross on the anterior surface of the skin is beneath the small hole (G) in the distal end of the upper caliper arm.

4. Place the vertical indicating rod or pointer into the hole and let it rest on the skin at the center of the cross (Fig.3)

5. Place the stop (S) on the indicating rod (V) at the distance above the horizontal rod (C) that the foreign body is beneath the skin, and fasten the stop by a set screw.

6. Place the collar that slides up and down on the vertical rod against the undersurface of the horizontal rod, and fix it with a set screw.

7. If the line of incision is to be through the anterior surface, fix the part firmly in this position with sandbags. Disengage and remove the upper arm of the caliper without moving the lower horizontal arm, the latter remaining fixed by its point in the washer or glove clasp.

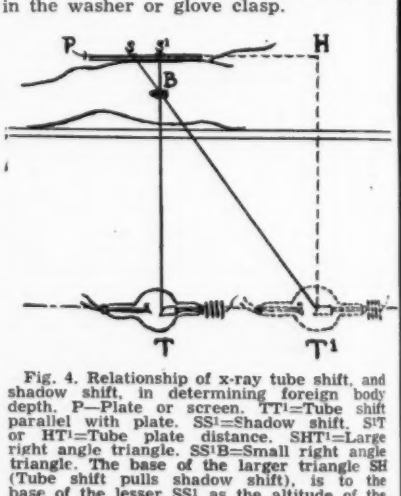


Fig. 4. Relationship of x-ray tube shift, and shadow shift, in determining foreign body depth. P—Plate or screen. TT^1=Tube shift parallel with plate. SS^1=Shadow shift. S^1T or HT^1=Tube plate distance. SHT^1=Large right angle triangle. SS^1B=Small right angle triangle. The base of the larger triangle SH (Tube shift pulls shadow shift), is to the base of the lesser SS^1 as the altitude of the greater HT^1 is to the altitude of the lesser S^1B. Therefore $\frac{SH}{HT^1} = \frac{SS^1}{S^1B}$. If the tube plate distance were 50 cm., and the tube shift 15 cm., and the shadow shift 2 cm., then substituting these values in the above equation, $\frac{17}{50} = \frac{2}{X}$ or $17X=100$. Solving: $X=5\frac{15}{17}$ cm., or the depth of the foreign body beneath the skin surface.

8. An incision is then made to a point approximately the depth of the foreign body, and if not immediately encountered, readjust the upper arm with its pointer and profondometer which will indicate exactly how far and in which direction to search.

9. If the surgeon wishes to make his incision at any other point on the circumference of the part, the oblique indicator (K) may be used.

Demonstration

The accuracy of the two point caliper method for localization and extraction was used on a wax model by the Army Officer in charge of roentgenology for the U. S. Army. This Army surgeon made a small triangular incision, and through this small incision, using the surgical calipers as a guide, he excavated a small conical hole, about the size of one's little finger and hit the foreign body "square on the nose" the first time he had ever seen or used this caliper.

Prior to this procedure, the same Army officer who had designed and superintended the construction of the apparatus now employed by the U. S. Army, used this identical wax model in an attempt to locate the same foreign body by his method, now employed by the Army. In an unsuccessful search for the foreign body he mutilated the wax model so, that one could put three fingers into the hole, but he did not find the foreign body.

The reason for the inaccuracy of the method of localization beneath only one known point, employed by the Army, when used on any part of the body is because it may have turned an undetermined amount between the time the roentgenologist located the foreign body and the surgeon extracted it (see Fig. 5). The fundamental principle of this method which is necessary for the accurate localization and extraction of foreign

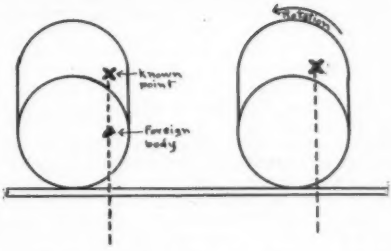


Fig. 5. Illustrates that the location of a foreign body on a vertical line under one known point may not be re-located, because of rotation.

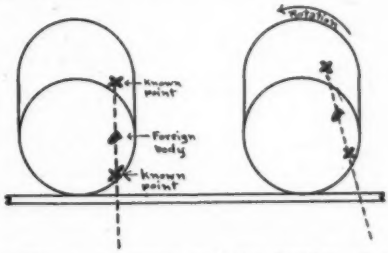


Fig. 6. Illustrates that the location of a foreign body between two known points, on a vertical line, may be re-located regardless of rotation. In actual practice, angles are not desirable, but previous position may be definitely determined by re-rotating the points until again vertically aligned.

bodies, is that the foreign body is located definitely, between two known points on the surfaces of the body. (See Fig. 6)

The accuracy of the caliper method was shown when employed in one of the most difficult problems of localization, namely, a very small fragment of a needle located deep in an axilla, about

Comparison

A tabulated comparison of the Army x-ray field unit and localizing device and the one herein suggested, was recorded in the American Journal of Surgery, as follows:

ARMY METHOD	THIS METHOD
1. Valuable only as a complete unit.	1. Usable on any horizontal fluoroscope.
2. Localizing device and necessary equipment weigh approximately 1000 pounds.	2. Localizing apparatus and film processing equipment weigh approximately 50 pounds.
3. The x-ray unit and localizing apparatus weigh more than a ton (estimated).	3. The x-ray unit and localizing equipment weigh approximately 150 pounds.
4. Ship only by boat, train or truck.	4. Can be flown anywhere.
5. Fluoroscopic examination only.	5. Both fluoroscopy and roentgenology.
6. Can be used only in total darkness, in lightproof and airtight black tent.	6. Used in any moderately light place, in the open, if necessary.
7. Surgeon has only the roentgenologist's word description.	7. Surgeon can see size and shape of the foreign body for himself.
8. No mechanical device to guide surgeon.	8. Very accurate guide for the surgeon.
9. Cost $4,000 (approximate).	9. Cost $500 (estimate).
10. Speed for examination said to be 20 per hour.	10. Speed same.
11. Used for all kinds of x-ray work, but patient must be brought to apparatus.	11. All kinds of diagnostic work — portable unit can be taken to patient without disturbing him.

halfway between the anterior and posterior surfaces. Yet this small fragment of a needle, deep in the axilla was removed within forty seconds after superficial hemostasis was established.

The Surgeon General's Office was fully aware of these facts as early as July 17, 1942, but refused to use this device or to have the Army apparatus put in competition with this two point caliper method, the data of such a comparison to be recorded by an unbiased person and submitted to an unbiased lay jury, such as has decided the question of life and death in thousands of persons for more than a hundred and fifty years.

Only by a plea to the new Surgeon General, can this simple device be made available for use on the boys at the front, who are doing such a grand job.

The roentgenologic and surgical calipers, and the technic of employment were fully described in an article published by the author while he was a major in the last war. This, of course, was then published with the consent of the Surgeon General.

References

(1) Cole, L. G. *Am. J. Radiol.* 14:271 (Sept.) 1917.

Additional Note

In response to an inquiry to the Surgeon General's office regarding the Army method of localizing foreign bodies, herewith is printed the reply received from Lt. Col. B. N. Carter, M. C., Assistant.

Dear Dr. Gorrell:

I am directed by the Surgeon General to acknowledge your letter of June 15 concerning the Army's method of localizing foreign bodies.

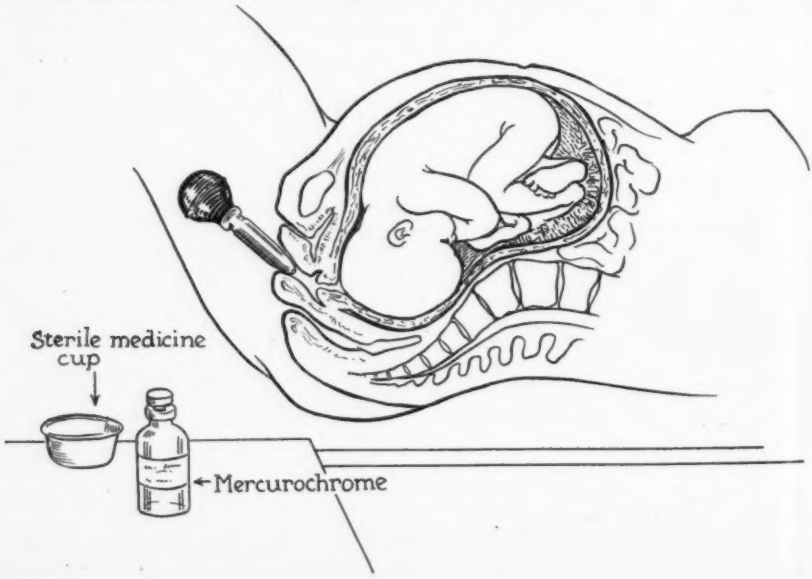
The method utilized by the Army is the triangulation method using a marked fluoroscopic screen. In addition to this, a reorientation device is utilized so that the foreign body is localized in two planes.

The Army is interested in and is investigating foreign body locators which are based upon electronic principle.

Vaginal Antisepsis During Labor

Dr. Maye's article in the December 1943 issue of CLINICAL MEDICINE, has aroused so much interest and letters inquiring as to technic, that there is presented herewith a sketch by our staff artist, Miss Victoria Catalani, depicting the simplicity of the method.

The asepto rubber bulb syringe is introduced into the vagina of the patient after the onset of labor and the vaginal canal irrigated with a 2% mercurochrome solution every 12 hours until delivery. This procedure, if carried out regularly during labor and preceding examinations, in all vaginal deliveries, will practically eliminate puerperal infection in maternity practice.



Phenyl-Propyl-Methylamine Hydrochloride for Asthma

A Clinical Study*

By KURT GLASER, M.D.,† *Louisville, Kentucky*

THE use of ephedrine and epinephrine for the symptomatic treatment of asthma has certain disadvantages, notably that of causing such undesirable side-actions as nervousness, insomnia, rise in blood-pressure and other untoward symptoms. A number of ephedrine-like compounds have been developed recently which have broncho-dilating action but which produce a minimal degree of side-actions. Certain pharmacological properties of a new sympathomimetic amine, phenyl-propyl-methylamine,‡ indicate it might be useful in the management of allergic conditions and this report deals with its clinical study in a series of asthmatic patients.

Vonedrin is a secondary amine; the hydrochloride is a white crystalline salt with a melting point of 144° C. It is very soluble in water and alcohol; slightly soluble in acetone and insoluble in benzene, chloroform and ether. The molecular weight is 185.6.

Pharmacological study of this new amine shows that it is of the same order of toxicity as ephedrine. In the laboratory animal, this compound possesses approximately the same degree of pressor action as ephedrine and beta-phenylisopropylamine, but it produces only a very small degree of central nervous stimulation. Daily administration to laboratory animals over a period of four weeks did not produce a great loss in weight nor any apparent gross pathology.[1,2]

Vonedrin Hydrochloride‡ Tablets were supplied for use in the treatment of allergic conditions in order to study its therapeutic value, as well as to determine the nature of the side-actions in humans. Complete studies were made in ten patients. These studies include in addition to clinical observations as to the value of this drug, certain observations as to the side-actions experienced.

The patients in this series were taken at random from patients attending the Pediatric or Allergy Clinic of the Louisville General Hospital, both colored and white, male and female. Two of them were hospitalized at the Children's Free Hospital. All were suffering from bronchial asthma, and all had a complete physical examination, skin tests and x-ray or other laboratory studies as indicated. The results of the skin test showed that the cause in one case of the asthma was intrinsic, two cases were extrinsic and six cases were due to combined factors. One patient was not tested. Most patients had received regular desensitizing injections prior to treatment with Vonedrin Hydrochloride.

These tablets were supplied in 10 mg. and 25 mg. sizes. At first smaller doses were given, but after a period of one to two weeks, only the 25 mg. tablets were used in doses varying from three to eight tablets daily. Administration was continued between five and six months in the series and observations were made on the pulse rate, blood-pressure and degree of central nervous stimulation.

As far as possible, with the exception of vital capacity tests, we have attempted to follow the suggestions for the evaluation of synthetic ephedrine products, as made by Dr. Vaughan.[3]

Symptomatic improvement was noted in six of the ten patients, but we realize that this is not a large enough series of patients to determine the clinical benefit of this new drug. The chief object of this study was to determine its action in the body and its effect upon the cardiovascular system and central nervous system. Pulse rate and blood-pressure of all patients were tested by the same individual before, during and after treatment. Electrocardiographic studies were made in two patients, blood sugar determinations were made in one patient. Results of these studies are shown on Table 1.

An interesting observation was the effect of this drug on the circulatory system. From the pharmacological studies it would appear that the administration

*Appreciation is expressed to Dr. John Walker Moore, Dean of the School of Medicine of the University of Louisville, and to Dr. Armand E. Cohen, Chief of the Allergy Clinic of the Louisville General Hospital, for their valuable assistance rendered in this investigation. Presented in part before the American Society of Pharmacological and Experimental Therapeutics, Inc. Boston Meeting, April, 1942. (Federation Proceedings, 1:143, 1942.)

†Assistant Resident in Pediatrics Louisville General Hospital.

‡Vonedrin brand. This work was done under a grant from The Wm. S. Merrell Company, Cincinnati, Ohio, and the drug was kindly supplied by this firm.

TABLE I.

Case	Allergy Observation Time	Medication prior to our series	Dosage of Vonedrin	Blood-Pressure	Pulse	Weight	Sleep and Nervousness
1) A. R. McG. 71 years white, male	Combined 4 months	Ragweed, M. Grass, M. Vacc. Adrenalin, Ephedrine	25 mgm. 8 times/day	Decreased from 160/100 to 130/70	Stable	Gained	Improved
2) L. D. 70 years white, male	Intrinsic 5 months	Mix. Vaccine Ephedrine	25 mgm. 6 times/day	Decreased from 190/90 to 170/80	Stable	Lost	Improved
3) J. W. 62 years colored, male	Combined 4 months	Ragweed, M. Grass, Mix. Vaccine	25 mgm. 6 times/day	Unchanged 120/80	Stable	Stable	Improved
4) F. DiC. 60 years white, male	Extrinsic 4 months	House Dust, Adrenalin	25 mgm. 8 times/day	Decreased from 180/110 to 125/80	Stable	Gained	No Disturbance
5) C. S. 49 years white, male	Combined 5 months	Mix. Vaccine Ragweed	25 mgm. 6 times/day	Unchanged 130/90	Stable	Gained	Improved
6) A. E. 16 years colored, male	Extrinsic 4½ months	Mix. Grasses House Dust	25 mgm. 4 times/day	Unchanged 110/80	Stable	Gained	No Disturbance
7) D. D. 14 years white, female	Combined 5 months	Mix. Vaccine House Dust	25 mgm. 3 times/day	Unchanged	Stable	Gained	No Disturbance
8) B. R. V. 9 years colored, female	Untested 5 months	None	25 mgm. 6 times/day	Unchanged	Stable	Gained	Improved
9) M. L. 9 years white, male	Combined Children's Hosp. 34 days	Adrenalin Aminophyllin	25 mgm. 4 times/day	Unchanged 100/70	Stable	Gained	No Disturbance
10) D. P. A. 9 years white, male	Combined Children's Hosp. 21 days	Aminophyllin Adrenalin Ephedrine	25 mgm. 6 times/day	Unchanged 118/74	Stable	Not Chkd.	No Disturbance

of Vonedrin to humans would be attended by a pressor effect, evidenced by an increase in pulse rate and in blood-pressure. It will be noted from Table 1, that there was no change in pulse rate, and contrary to what might be expected, the blood-pressure either remained unchanged or was actually reduced. We realize that the reduction in blood-pressure may not be due to any direct action of the drug upon the cardiovascular system, but was due most likely, either to symptomatic improvement, or to lack of central nervous stimulation. Electrocardiographic studies showed no change in the tracing when the patient was under the influence of the drug.

There were no symptoms of central nervous stimulation in any one of the series. There was no mydriasis, tremor, or any disagreable symptoms whatever reported by this group. Patients who were nervous at the beginning of therapy became more quiet and in no instance was insomnia reported. In general the group did not lose weight.

Summary

A new ephedrine-like compound phenyl - propyl - methylamine (Vonedrin brand) hydrochloride, was investigated on a series of patients suffering from bronchial asthma.

In order to determine the clinical efficacy, the general condition of the patient, the number and severity of attacks was used as a standard of comparison. It was found that the efficacy of Vonedrin was at least equal, if not superior to that of ephedrine. The toxicity and production of unpleasant and undesirable symptoms was certainly less marked than from epinephrine or ephedrine, while it is not as efficient a bronchodilator as epinephrine.

Electrocardiographic studies and studies of the blood-pressure, pulse rate, weight, and observations on central nervous stimulation were made to indicate any undesirable side-actions. It was found that there were no undesirable symptoms in this group and it was significant this drug does not have any pressor action. There was no insomnia or nervousness experienced in this group from doses of Vonedrin ranging from 75 to 200 mgs. daily.

Bibliography

(1) Pharmacological Studies on dl-B-Phenyl-propyl-methylamine, a Volatile Amine; T. J. Becker, M. R. Warren, D. G. Marsh, C. R. Thompson and R. S. Shelton, Department of Pharmacology, Research Laboratories of The Wm. S. Merrell Company, Cincinnati, Ohio—(In press).

(2) Central Stimulation Studies on a number of Amines; R. S. Shelton, Warren Becker and Van Campen, Fed. Proc. Vol. 1, pg. 165 (1942).

(3) Warren T. Vaughan, M.D., Rollin M. Perkins, M.D., and Vincent J. Derbes, M.D., Richmond, Va. Epinephrine Analogues and their clinical assay. The Journal of Laboratory and Clinical Medicine, Vol. 28, No. 3 December, 1942.

Oral Treatment of Tuberculosis with Diasone*

(Summary of Preliminary Reports)†

By CHARLES K. PETTER, M.D., F.A.C.S., *Waukegan, Ill.*

THE tubercle bacillus is a peculiar, unpredictable organism capable of producing innumerable disease manifestations. Similarly variable are the dose and virulence of the infecting agent, the resistance and response of each individual to such infestation, and the attitude of the patient toward his disease and treatment.

Accordingly, at all times, we are compelled to reckon with the variables of the "host invader" complex, no matter what therapy is employed.

With the administration of Diasone (formaldehyde sulfoxylate diaminodephenyl sulfone) to these groups of patients, favorable changes have been observed in the majority, in a shorter time and of greater degree than would reasonably be expected on the regime employed witnout the compound.

Treatment

At the start, 1.0 gm. a day of Diasone was administered orally to all patients (.033 gm., three times a day, with meals). After a time, the administration was changed to 1.0 gm. a day for 3 days, then 2.0 gms. a day for 3 to 5 days (0.66 gm. with meals), then reduced to 1.0 gm. a day. This seemed to quicken and maintain better tolerance of the patient.

Toxic Effects

Of 108 cases, 4.6% were taken off the treatment because of intolerance.

Diasone produces a decided depression of the red cell count and hemoglobin which, however, recovers without adjunct medication. Most patients experience some gastric upset, headache, palpitation and malaise but these were not alarming, unbearable, or irreversible and for most patients they improved as toleration developed.

Occasionally visual disturbance and "blue skin" was noted.

Observations

Therapeutic: As the patients developed tolerance to Diasone, general well being improved and body weight remained the same or increased. Cough and expectoration increased, at first, then subsided. Sputum, as a rule, became less purulent and less tenacious, and conversion from positive to negative (24 hour concentrate) was observed in 59% of patients. Table 1 outlines general improvement noted in these cases.

X-ray: Clearing of parenchymal infiltration occurred in 75% of patients. Some cavities became smaller and some disappeared. Some showed an increase in parenchymal shadows followed in 2 to 6 weeks by resolution. Cavity closure or at least disappearance of cavity outlines occurred in 40.2% patients (average of both reports).

Laboratory: Decided changes took place in the erythrocyte count and hemo-

*Diasone—Experimental product of the Abbott Laboratories, North Chicago, Ill.

†Two papers, the first covering 44 cases, the second covering 108 cases, have been reported to various medical groups. These have not as yet been published. Due to premature publicity in the lay press, these notes, taken from a personal interview (January 1944), are published for the medical profession. [Ed.]

TABLE I

Pulmonary Classification	Number of Cases	Disc. Treat.	Cases Treated 60 to 120 Days	Dead	Worse	No Change	Cases Improved			Recap. of Improvement (Cases Treated)	
							Slight	Moderate	Marked	Totals	Percentage
Minimum Advancement	16	2	14	0	0	0	2	6	6	14	100%
Moderately Advanced	82	15	67	0	2	2	13	13	19	63	94%
Far Advanced	44	9	35	3	4	1	12	10	5	27	77%
Totals	142	26	116	3	6	3	27 (23.2%)	47 (40.5%)	30 (25.9%)	104 (91.6%)	Improvement in entire 142 cases (73.2%)

General Therapeutic Summary of 142 Cases of Pulmonary Tuberculosis Treated with Diasone.

globin content of the blood. The white blood elements were not adversely affected and neutropenia was not observed. There was initial increase in monocytes followed by a later drop, with consequent improvement in lymphocyte-monocyte ratio. A gradual drop in the erythrocyte-sedimentation rate was observed in all patients who made clinical improvement.

Kidney and liver damage was not observed clinically or by histologic studies. By the administration of 1.0 gm. of Diasone daily, the blood levels were maintained at well over 1.5 mgms. in 100 cc. of blood. Only three patients had pneumothorax or phrenic nerve interruption after Diasone treatment was started.

Summary

From the above preliminary summary, I am convinced that further application of Diasone to clinical tuberculosis, is very definitely in order, especially in patients with infiltrative lesions without extensive tissue destruction or massive fibrosis.

Diasone will not be available for general use for many months, and a great deal of investigation remains to be carried out.

While the ideal chemotherapeutic agent for tuberculosis has not been found, Diasone seems to be an advance toward that goal and possible new derivations which our research chemists must provide, sooner or later, may despell the idea that there can be no effective chemical to combat human tuberculosis.

Lake County Tuberculosis Sanitarium.

Treatment of Common Eye Diseases

Sty (hordoleum): In the acute stage, warm or hot applications are used until the sty "points," at which time it is opened with a small sharp knife.

Recurrent styes call for: (1) Refraction to detect visual errors, (2) 5 percent sulfathiazole ointment used in the eye twice daily, (3) mechanical cleansing of lids with cotton and warm water (look closely to see if pediculi are present) and, (4) injections of staphyloccocic toxin or toxoid, if unrelieved.

Marginal blepharitis: (1) Remove crusts with cotton and warm water. (2) two percent ammoniated mercury ointment, (3) painting margin of lids and root of lashes with half-strength tincture of iodine for stubborn blepharitis, (4) painting with 2 percent tincture of brilliant green in 70 percent alcohol for crusts and weeping secretions.

Chalazium (retention cysts of meibomian glands): Use of a mild eye antiseptic solution, with gentle massage and heat, permit many of these chalazia to open up and discharge their contents through the normal gland opening. Those that do not regress should be incised through the conjunctival surface and curetted or destroyed with a caustic agent.

Acute catarrhal conjunctivitis ("pink eye"): In the acute stage, dark glasses, ice compresses and this prescription are of value:

℞	Zinc sulfate	gr. i
	Boric acid	gr. x

Those cases that do not respond promptly to simple treatment should use zinc sulfate ¼ percent in water and have the conjunctival surface of the lids painted with 1 or 2 percent silver nitrate solution.

Chronic conjunctivitis may be kept up by infection in the lacrimal sac, which may require irrigations or probing of the lacrimal duct.

Gonorrheal conjunctivitis is treated by sulfonamides in adequate doses and occasional cleansing with normal saline or half saturated boric acid solution. *Don't mistake inclusion blennorrhea in newborn babies for gonnorrheal conjunctivitis;* in both, there is a profuse outpouring of pus. A short course of sulfonamides will clear it up.

Vernal catarrh: This is an allergic condition that is relieved temporarily by 1:1,000 epinephrine instillation; a more permanent result is obtained with 3 percent sodium bicarbonate (this must not be given at the same time as the epinephrine).

Chemical burns of the eye: Wash out at once with water, under a hose or water faucet. The lids must be forced open (do not injure the eye with a strong stream of water). Afterward stain the eye with fluorescein solution to see if the cornea is damaged. If so, protect the eye with a mild ointment or oil (mineral oil) and send the patient to the ophtholmologist. — Therapy Conference, *N.Y.S.J.M.*, May 1943.

Notes From the International Postgraduate Medical Assembly, II*

Reported by RALPH L. GORRELL, M.D., *Buffalo, N. Y.*

GALLBLADDER DISEASE

By JOHN F. ERDMANN, M.D.
Attending Surgeon, New York Postgraduate Medical School, New York City

A gap in the common duct may be filled in with a Vitallium tube.

The technique should be varied, depending on the condition found. The procedure of removing a gall bladder from below upward, after locating the cystic duct, is usually the best. The painless onset of jaundice is very suggestive of malignancy.

Dyskinesia of the gall bladder should be treated first with nitrites and other anti-spasmodics. If no relief follows, the abdomen should be explored. Surgical treatment is not advised until medical treatment fails because 40% of patients are not relieved by surgical procedures.

Acute cholecystitis should be treated by immediate removal of the gall bladder because nature's inflammatory defense is present. Chronic cholecystitis should be treated by removal of the gall bladder. This is especially true if stones are present because malignancy is only found in association with stones, and because of the possibility of liver damage.

Patients with gall bladder disease quite frequently lose in weight, often in large amounts.

The steady, painless onset of jaundice accompanied by loss of weight and weakness, is indicative of malignancy.

Intermittent jaundice suggests a gall stone with ball valve action.

Gangrene of the gall bladder is suggested by exquisite tenderness and marked resistance to abdominal palpation. The pain is usually extreme and the blood count high. An empyema of the gall bladder, which has persisted for some time, is often not accompanied by change in the blood count and is productive of little tenderness.

Drainage of the gall bladder should not be done in the great majority of cases because a fistula frequently follows, due to a stone being left in the cystic duct, or in the common bile duct. After drainage of the gall bladder, the cholecystomy may close, only to open up later or to be opened and discharge bile and pus.

We believe that liver deaths are often due to injury to the hepatic artery during removal of the gall bladder. A short cystic duct presents a difficult problem to handle surgically.

*Part II of this series of Notes. To be concluded next month with part III.

COMPLICATIONS OF APPENDICITIS IN INFANCY AND CHILDHOOD

By HARRY A. OBERHELMAN
Professor of Surgery
Loyola University, Chicago, Illinois

In the children's ward at Cook County Hospital, these facts have been proved: Appendiceal abscesses should be managed conservatively with (1) rest, (2) intravenous feeding, (3) sulfonamides, (4) plasma as needed and (5) heat or cold to the abdominal wall.

Those patients with generalized peritonitis are operated upon as soon as they are prepared for surgery. Blood is usually given during operation. Mortality rate with surgery was 4.7 percent, far less than when the patients were not operated upon.

700 child patients with various types of appendicitis were operated upon by 52 different surgeons, with an average mortality rate of 2.2 percent. The large group of surgeons indicates that individual surgical technical differences played no part, and children's tissues are delicate.

Types of Appendicitis	Treatment
Acute non-perforated appendicitis	Immediate operation
Perforation and abscess formation	No operation
Perforation and general peritonitis	Immediate operation

(Immediate: After the patient is built up properly)

INDICATIONS FOR GASTRIC ULCER SURGERY

By W. H. COLE, M.D.
Professor of Surgery
University of Illinois, Chicago, Ill.

Gastric surgery is performed for tumors of the stomach ulcers which are: (a) intractable, (b) perforated, (c) bleeding, or (d) obstructive.

Bleeding ulcers: Hemorrhaging patients must be operated upon in the first

two days. Never delay the operation for many days, as the outcome is frequently fatal.

At least five blood transfusions of 500 cc. each (one pint) may be needed to bring the blood count back to normal; an additional three transfusions may be needed, keep in reserve, to give blood during and after the operation.

It is the posterior penetrating ulcer that usually bleeds; one must get behind the duodenum or ligate the bleeding artery after opening the stomach. A skilled surgeon is needed.

Perforation: The history of ulcer-type pain is not necessary for a diagnosis, as one-fifth of patients with gastric ulcer have had no symptoms preceding. Such patients are *not in shock*, as contrasted to the true shock of hemorrhage because pulse and blood pressure are normal. Hemorrhage leaves the patient weak, he "faints" and collapses to the floor, his pulse is 120 or faster and his blood pressure drops.

Case History No. 1

This man, aged 45, has had a gastric ulcer for 20 years. Foods or alkalies have always relieved his distress.

For the past five weeks, he has had *cramp-like pain* without relief from alkalies or food. Good medical care has not provided relief from pain, although vomiting has been controlled. X-ray: At the end of 6 hours after the barium meal was given, 90 percent of it was still in the stomach. Free hydrochloric acid was 40 and combined 24, making a total acidity of 64; an alcohol meal resulted in a total acidity of 128.

Crampy pain indicates that an obstruction is developing. Ulcer pain itself is mild. The pain of a complicated ulcer is severe, especially if obstruction develops. The pain of obstruction is milder.

Treatment: To determine if a spasm is the cause of the pyloric obstruction, the patient was put to bed for a few days, and sedation given. No relief followed and a resection was done for the duodenal ulcer.

Indications for operation in obstruction: 1. The amount of vomitus is not a good criteria as to the need of operation. This patient vomited little because he cut down his diet markedly. 2. It must be remembered that there is no medical cure for pylorospasm, and that delay only makes a poorer surgical risk. 3. The mortality rate for resections is 6 percent for duodenal ulcers (we have had no fatalities in the last 35 resections for gastric ulcers; in such cases, one does not have to mobilize and close the infiltrated duodenal stump, with resultant chance of leakage).

Postoperative care: For a few weeks, slight nausea and burning may appear. We do not fear jejunal ulcer if high resection is done, as so much of the acid bearing area in the stomach is removed that there is not enough acid to cause a recurrence of the ulcer.

Following such surgery there is little need for treatment. The patient may eat an average diet, avoiding raw and spicy foods, and limiting alcohol and tobacco markedly.

Case History No. 2

A man of 60 has noticed *fatigue, epigastric pain,* especially nocturnal; *vomiting* after meals, and *black stools* for 5 weeks. The pain is typical of peptic ulcer but there is more vomiting than usual after meals. The stools were black for one week at the onset. X-ray: An ulcer on the lesser curvature was found. Gastric acidity was 34 total, no free acid being found. Because of the hypochlorhydria, (which should not be used as the only criteria) and the patient's age, the possibility of malignant tumor was suspected.

A small indurated ulcer was found at operation. Resection was performed and pathologic study showed it to be benign.

Indications for operation: If an ulcer is large, there is a greater chance of it being malignant. Hemorrhage in an older person is an indication, as they do not stand repeated bleeding well. Their sclerotic arteries tend to permit bleeding to continue. *A malignant ulcer may be relieved* by medical therapy and even show some signs of healing on x-ray examination. This is due to a decrease of the inflammatory mass around it. Older persons should not have prolonged medical care. Resection should be carried out in persons in the cancer age. Medical treatment should be carried out in younger persons. Gastric ulcers may be resected with a very low mortality rate.

Case History No. 3

A woman of 50 complained of burning, gnawing pain for 5 years (such a long course suggests benignancy). The pain has been gradually increasing, and with less consistent relief by alkalies. An ulcer niche was found near the ylorus. The total acidity was 28, and no free acid was found. (These findings closely resemble those in the preceding case.) At operation an indurated ulcer was removed which could not be definitely diagnosed at the operating table. Sections showed adenocarcinoma.

Case History No. 4

A man of 28 years, complained of epigastric pain for 2 years. This pain came on ½ to 1 hour after meals and was accompanied by belching; this was us-

ually relieved by food or alkali. For 6 months, he has had no relief despite good medical care, and cannot do heavy work as it causes an increase in the pain. A duodenal ulcer was demonstrated. Despite the fact that no free acid was found (total 14), the diagnosis of *intractable ulcer* can be made. Such cases should be treated by wide resection, if operated upon, because there is danger of jejunal ulcer postoperatively.

THE DIAGNOSIS OF COLONIC CANCER

By FRED W. RANKIN, M.D.
Lexington, Kentucky

The right and the left halves of the colon differ, both in development and function:

Development	Function
Right colon — Develops with small gut; has same functions	Absorbing
Left colon — Develops from hind gut	Storehouse

Polyps of the Colon

Polyps of the colon often become carcinomatous. When discovered during colonic x-ray study or by sigmoidoscopy, they should be considered pre-cancerous and removed or destroyed. There is a strong familial tendency, and other members of the family should be studied for polyps.

Symptoms of Colonic Cancer

Right half of colon: (absorbing; liquid stream so no obstruction)	1. anemia 2. indigestion 3. accidental discovery during routine x-ray
Left half colon: (firm movement)	1. Change in bowel habit 2. obstruction in practically all cases 3. bleeding

Anemia is the leading symptom in ⅓ of right colonic cancer patients. The patients are definitely pale, they tire easily and laboratory examination shows a definite secondary type of anemia. The x-ray is usually diagnostic in this type of cancer (it cannot often be palpated).

Vague indigestion or dyspepsia not definitely related to stomach function is fairly common, in right half tumors.

Left half cancers are obstructed to some degree in practically all cases, except those found accidentally. Change in bowel habit is an *early* symptom.

Do not refer the patient with suspected large bowel neoplasm to the x-ray man until a rectal examination has been done (remembering to have the patient strain down so as to bring a high lying rectal growth down to the finger) and the sigmoidoscope used to see (1) if there is a cancer, (2) to learn if obstruction is present, (3) to determine its location. Barium should never be given by mouth if a colonic tumor is suspected because (1) it is useless, as the colon is not outlined well unless the barium is given in concentrated form as an enema into a well cleansed colon and (2) it is dangerous due to the possibility of a complete obstruction occurring where the barium meets the narrowed bowel lumen.

Surgical Procedures

The surgeon should see (1) that the bowel is well cleansed with laxatives and many enemas and (2) that a wide spread resection of the bowel, including surrounding tissues and lymph nodes is done.

Right half colon cancers are preferably treated by a two-stage operation, which permits the "by-passing" of fecal matter around the inflamed area until resection can be safely done. If an infected loop is mobilized, one takes chances with infection. Peritonitis is produced by touching such infected tissue. If the loop of bowel containing the tumor is freely movable, not inflamed and not fixed, a resection may be done at once. Fixation is often inflammatory, not a local extension of the tumor and should not contraindicate operation.

Left half colon may be treated by primary resection or preferably by obstructive resection, with the clamps left on. The resection may be accompanied by a cecostomy.

SIGNIFICANCE OF BLOOD IN THE URINE

By HERMAN L. KRETSCHMER, M.D.
Professor of Urology
Rush Medical College, Chicago

Blood in the urine always signifies serious organic disease. *Do not give any medicine* until a diagnosis has been made, as bleeding in the urine always stops and the patient, and too often his physician, have a false feeling of security.

Essential hematuria is an incorrect phrase, as the great majority of patients with hematuria have a definite organic cause: First, stone; second, tumor; third, tuberculosis; fourth, infection, or five, nephritis. On a few occasions, thorough diagnostic study does not reveal the cause of bleeding. In such cases, the patient may have passed a silent kidney stone or an acute colon bacillus

infection may have caused bleeding, yet the infection has disappeared spontaneously before the study is made.

Generalized causes of hematuria are (1) infections, (2) poisons and (3) intoxications. Foci of infection may cause hematuria. High blood pressure may cause hematuria. Purpura results in hematuria. An enlarged prostate may cause hematuria.

Routine Examination

If the patient gives a history of blood mixed all through the urine, it probably was of renal origin. If the blood appears in the last urine voided (or is found in the second glass of the 2 glass test), it is of bladder trigone origin. Recent infections, especially head infections in children, may affect the kidneys. One should ask about cough, as tuberculosis may be the cause. Especially ask about the previous passage of a stone.

The physical examination is important. One may be able to palpate polycystic kidneys, hydronephrosis and renal tumors. Rectal palpation should be carried out as one-fifth of patients with bladder neck obstruction have cancer. Vaginal examination will indicate if the blood is coming from the cervix, as in menstruation, or will disclose cancer of the cervix or uterine fibroids. Examination of the mouth may show infected tonsils or teeth which are acting as a focus of infection.

The diagnosis of polycystic kidney is a clinical one. There is often a family history of kidney disease and death. The clinical picture is that of nephritis.

Laboratory Findings

If the laboratory findings fit in with the clinical picture, fine. If they do not, put them in the wastebasket.

X-ray diagnosis of renal lesions may be very deceptive. Intravenous urograms should be checked by retograde pyelograms, to avoid operating upon kidney "tumors" which aren't there.

Wrong Use of Folliculine (Estradiol, Feminine Hormone)

By DR. EDUARDO CRUZ COKE,* *Santiago, Chile*

FOLLICULINE, also known as estradiol (Theelin), or feminine hormone, is indiscriminately used.

Ignorance of the fact that it is only one of the many factors involved in the mechanism of menstruation, and that amenorrhea is not always a symptom of feminine hormone insufficiency, is the principal cause of the error committed in its use.

Menstruation is due to the correlation of many factors, some of them neurovegetative and humoral. This is the reason for the increased importance of drugs like Yohimbin and Prostigmin; their vascular action in the uterus precipitates the menstrual phenomenon. This cannot be produced even with an artificial increase of the blood concentration of folliculine already present at a normal level.

Ascorbic acid must also be present in normal concentration for the appearance of the menses.

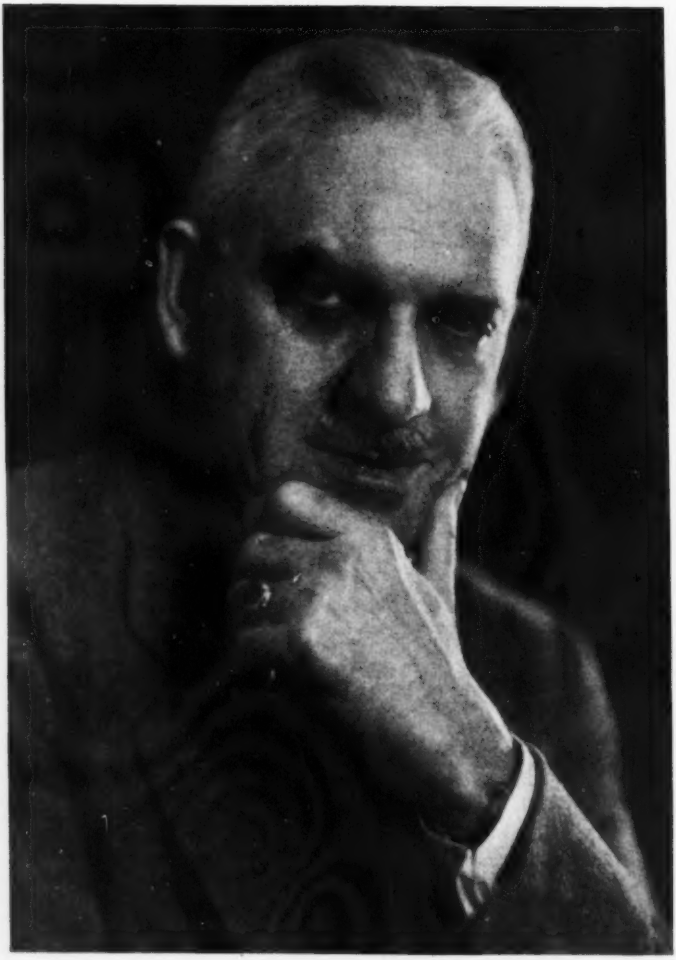
Briefly, the use of folliculine must be attached to a knowledge of its blood level; this may be known not only by means of an elaborate and expensive laboratory procedure, but from the observation of some clinical and morphologic aspects which we do not need to describe now.

In women older than 35 or 40 years, the use of folliculine, when indicated, is not dangerous, but in girls or young women, it produces an inhibition of the pituitary's anterior lobe and thus of the future secretion of folliculine. This is why many physicians, acting with the best of intentions have sterilized their patients by means of this apparently harmless treatment, because of premature inhibition of the stimulus for normal production of folliculine.

We must remember the classic experiments on the immature female mouse, whose ovary becomes atrophied following the injection of folliculine.

In young women, physicians must not use folliculine. This hormone, on the contrary, is indicated for those women whose ovaries are declining in function. For young women, one should prefer other products that do not substitute for ovarian function but stimulate it.

* Lab. De Quimica Fisiologica Y Patologica, Universidad De Chile.



GEORGE B. LAKE, M.D.

Editorial

George B. Lake, M.D.

A YEAR has gone since Dr. Lake left his work for CLINICAL MEDICINE and went on to other fields of endeavor.

The world of doctors and medicine was his world, in his blood, and in it he found his greatest happiness and contentment. The desire of his heart was to make the magazine he edited a constant help to all doctors in general practice, especially those of his "family"—the subscribers to CLINICAL MEDICINE.

He was born in Topeka, Kansas, but came to live with his grandfather in Michigan after the death of his father, who was a civil engineer, when he was about three years old.

His grandfather was a doctor and kept an old fashioned drug store, where he rolled his own pills, filled his own and other prescriptions (and played chess and read Greek verse with his friends when things were slow). There was also a small drug room at home and the stale smell of valerian, creosote, assafetida, bromine, squills and pipe tobacco permeated the house so he literally was brought up in the "odor" of medicine.

He went to Wheaton Preparatory School when he was thirteen. There he became interested in religion, which lasted the rest of his life. Later on, when it came to deciding which to make his life work, he hesitated—the priesthood or medicine. Medicine won, but his study and work along priestly lines were invaluable in his practice as it made his sympathy and understanding keener, and his eagerness to help greater. Actually, both of his vocational interests won, as in later life he was ordained a priest in the Liberal Catholic Church.

He worked his way through medical school, University of Michigan School of Medicine and Rush Medical College.

After graduating in 1909, he spent two years as surgeon of the Mexican Central Railroad, stationed at Silao, Guanajuato, after which he spent five years in private practice in a small town in Indiana.

It was after this that he entered Army Medical School where, after his regular commission, he served as surgeon for 13 years in the United States Army, until 1924 when he became Editor of CLINICAL MEDICINE, succeeding Dr. Achard.

When, in the course of human events, it becomes necessary for a man to leave his work here, unfinished, it takes a great deal of courage for the ones to whom his work is left to carry on—to try as best they can to live up to the ideals set for the magazine.

This could not have been done had it not been for the loyalty and support of Doctor Lake's many friends and for the loyalty of his large "family."

There are a few now who were in the family from the days of Dr. Abbott and Dr. Waugh and many more who have been faithful friends for many years. To all of them—to all who have helped carry on, very surely he must be with them in spirit.

His ideals for the betterment of general practice, and the magazine he so loved, will be kept living and his family of friends, with their help, will be served faithfully, always.

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Husk of Remembrance

(To the memory of Dr. George Burt Lake)

Oh, indiscriminate Death, you have defied
A hand that set for us the seed of truth,
The seed that God, Himself, had glorified
With ripened tassel and a bloom of ruth—
The seed of consolation from a store
Of beauty in his bright, immortal songs;
How surely they, as now and evermore,
Will serve to help retrieve a world of wrongs.

Not his the destiny to serve alone
With songs to elevate lethargic minds
But his the noble purpose to dethrone
All pain and sorrow . . .Each who knew him finds
His life made richer, though grim circumstance
Now leaves but husks of loved remembrance.

—*Jean Chalmers Donaldson*, 1943

Novocain Injection for Minor Injuries

THERE should be in every physician's office a 100 cc. bottle of one percent Novocaine or procaine solution, short and long needles and sterile syringes. With this almost innocuous remedy, pain can be stopped at once and often permanently, in many medical and surgical conditions.

Fractures, sprains, lumbago, neuralgia, pleurisy, low back pain and strains, "rheumatic pains," painful shoulders ("subdeltoid bursitis"), bruises, mashed toes, contusions, painful heels, painful scars and many other conditions can be relieved or cured.

Objections: The first prick is felt — true, and much research has yet failed to develop a perfect, simple anesthetic for the skin. Those physicians who have ice handy will find that a piece or cube of ice pressed on the skin to be injected for 40 seconds will so lower sensitivity that the needle will hardly be felt. The patient who experiences instant relief of pain minimizes the initial prick.

2. The pain may not be relieved. The pain is relieved if the physician carefully palpates around the area and locates one or two points which are exquisitely tender. Marking the points of complained tenderness first, then comparing them will usually show that the patient "winces" or "jumps" when only one point is pressed. The procaine should first be injected into the skin, to raise a wheal, then down into the subcutaneous tissues, be they ligament, muscle or tendon, until bone is reached or until pressure over the spot causes no pain. The point of tenderness (trigger point) may be located ¼ of an inch or 3¼ inches below the skin. The introduction of a slender needle (gauge 22) deep into the tissues does not cause harm.

The latest in a long series of articles on procaine injections for painful conditions has been published in *Surgery, Gynecology and Obstetrics** (Oct. 1943). The remarks above are personal. Those below concern this article.

After surveying their experience with Novocaine injections, they write, "During the year 1942, it was necessary to admit to the hospital 55 patients with acute sprain or strain of the knee, ankle or back. The average duration of hospitalization was 10 days. Since Novocaine injection has been used, we have admitted only one patient with severe traumatic synovitis of the knee for 2 days. Two patients with acute exacerbation of chronic low back strain have required hospitalization. *In no other knee or back and no acute ankle injuries have patients needed hospitalization* . . . Injuries to the ankle, knee, shoulder, wrist, back and miscellaneous injuries were treated."

They believe that the effect of procaine injection is due to (1) immediate decrease of muscle spasm and (2) delayed but important correction of local anoxia (oxygen lack). The muscle spasm causes a decreased muscle use and consequent slowing of circulation locally. The area of irritation results in vasodilatation and edema (sterile inflammation) with consequent lack of oxygenation of the tissues. The relief of pain permits return of normal vascular tonus and use of muslces, both of which permit normal circulation to be re-established (It is noted clinically that those ankles which are injected at once after injury do not swell; and those which are beginning to swell when injected do not swell any more.—Ed.)

They emphasize the importance of aspirating blood if a hematoma is present and injecting in this area, as the greatest possible amount of relief is obtained with the minimum of needle movement.

Every year, there are an increasing number of articles being written on procaine treatment of various painful affections. Although not a cure all, those who are using it and have experienced its relief personally, feel strongly that the profession as a whole is missing a great opportunity to relieve pain and help their patients. R.L.G.

*Murphy, Frank C. and Postlethwait, R. W. (Lieutenant and Captain, M. C., Army United States.)

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Growing Up

To grow up without thinking is merely to become older.

To grow up thoughtfully is to become wiser.

Maturity is measured in terms of wisdom.—MANLY P. HALL.

CLINICAL NOTES and ABSTRACTS

Microfilm copies of any of the published papers here abstracted, up to 25 pages, may be obtained for 25 cents from Microfilm Service, Army Medical Library, Washington, D. C.

Plasma for Laryngotracheobronchitis

The clinical entity laryngotracheobronchitis almost always affects young children. *Signs:* (1) Rapid onset of hoarseness, (2) laryngeal stridor, (3) difficult breathing, (4) fever and (5) cough.

The stridor progresses, sometimes rapidly, to almost complete laryngeal obstruction necessitating intubation or tracheotomy.

Cause: inflammatory edema in the trachea and bronchi, with thick, adherent secretions. Tracheotomy relieves the upper respiratory obstruction but 50 percent of patients die, due to lower obstruction and tremendous efforts involved in respiration.

Treatment: Human plasma, when given intravenously in concentrated (hypertonic) form, reduces the edema and respiratory obstruction, often without a tracheotomy being required.

1. Venesection: From 100 to 150 cc. of blood are removed first, to avoid overloading the circulatory system.

2. Dried human blood plasma (Lyophile process*) is usually supplied in 250 cc. size. Instead of adding the full amount of water (225 cc.) to bring it up to normal volume, I use 60 cc. of sterile water, thus making approximately a one-fourth dilution, or *plasma four times as concentrated as normal* (Lyophile plasma may be obtained from serum centers, supply houses, hospitals or some drug stores). The exact concentration is not important, so long as all the plasma is restored, without any dry lumps, and is not too thick to be passed through an intravenous needle.

3. During the time of preparation, oxygen, preferably moistened, should be given.

4. From 25 to 40 cc. of the four times concentrated plasma is given, depending on the size of the child and the severity of the case. A slight febrile reaction may follow, in one percent of cases.

5. *Results:* Almost before the injection has been completed, the patient becomes tranquil, the respiratory obstruction is gone, the breathing is quiet, color is restored and the patient falls asleep on the table. The disappearance of obstructive symptoms does *not* mean that the infection is cured. Also, the edema may return later, and the plasma administration needs to be repeated.

Other Uses

Other types of laryngeal or bronchial edema may be benefited, including obstructive laryngitis with edma, angioneurotic edema, edema of the larynx following trauma, edema during crises of bronchial asthma and post-bronchoscopic edema.

*Clyophile Process, Sharp and Dohme Pharmaceuticals, Philadelphia.

Sulfur in Oil for Dermatoses

The rational therapy of skin diseases is to apply soothing remedies to those of an acute inflammatory nature. Strong and stimulating agents are used in obstinate and chronic dermatoses.

Precipitated sulfur, 30 to 40 per cent in petrolatum, acts effectively in acute inflammatory dermatoses that fail to respond to the conventional mild and soothing applications. Pityriasis rosea, acute eczematous dermatitis, generalized acute seborrheids, and psoriasis of the erythrodermatous type, rosacea, and scabies, responded favorably to the sulfur concentrated paste. Infections eczematoid dermatitis and other eczematous parasitic dermatoses, impetigo, and sycosis vulgaris also may do well. The sulfur paste acts as an antiphlogistic, reducing, antipruritic, and antiparasitic

agent. Dermatitis, not uncommon with milder sulfur ointments, has not been observed following the use of 30 to 40 per cent sulfur in petrolatum. Irritation may appear. It is of a temporary nature and subsides with the further use of the sulfur paste. There is less close contact of the sulfur with the skin by the use of 30 to 40 per cent sulfur in petrolatum than with weaker sulfur ointments, allowing the therapeutic action of sulfur to assume the ascendancy over the less desirable and irritating effects.—E. W. ABRAMOWITZ, M.D., in the *N. Y. State J. M.*, April 1943.

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The Pharmacist Looks at the Physicians*

It is recognized that there are pharmacists who do not measure up to high standards. It is well worth the physician's time to determine the best pharmacists in his locality and send his patients to them.

How does the pharmacist look at you, the physician? He admires and respects you, as men and women, for your training and ability. You have made greater academic advances than the pharmacist and he is aware of the fact.

Frankly, the pharmacist is rather envious of the psychological hold the physician has on the public, but very often realizes that he would merit more confidence if he were as willing to work hard toward this end.

The pharmacist has an ideal of service to the public and to the physician. However, he feels that those he serves are not always satisfied with his actions, and he is usually at a loss for an explanation. The pharmacist feels that the physician is careless in writing and sending his prescriptions, in giving out samples, in referring to the charges for medicines and so on. Worst of all, he has a deep seated conviction that the physician does not sufficiently trust his judgment or integrity on matters pharmaceutical. The modern pharmacist's professional training has taken four years, and he has a degree recognized by major graduate schools.

That, Doctor, is the pharmacist's composite view of a composite you—a curious mixture of respect, admiration, envy and vexatiousness.

Insufficient Trust

The pharmacist, because he is a member of a service profession, feels that he has served the medical profession by stocking all items that each one wants, including the 76 brands of digitalis, as many vitamin preparations and so on. The result is a heavy overhead expense and needless, wasteful overstocking.

The physician should realize that the pharmacist must check prescriptions, and by phoning concerning a prescription, he is protecting the physician as well as himself. The pharmacist faces more rigid and frequent investigation of his handling of various drugs than the physician does.

The pharmacist feels that the physician is prone to distribute samples unnecessarily and thereby create the impression that medicines are inexpensive when such may not be the case. The pharmacist does realize that samples furnish a convenient means of trying new medications, or new combinations of old, and he has *no* desire to interfere with or contest your prerogatives.

He does not suggest the length of time to diagnose a case or set the doctor's fees. He would like to believe his time and charges were not indicated to the patients before they had brought the prescription to the pharmacy.

Summary: Too little trust is placed on the integrity and judgment of the pharmacist. The modern pharmacist's knowledge and training will surprise and aid you, if given a chance. He does not care to discuss these matters with you because he fears that he may be rebuffed. More contacts and conferences between physicians, pharmacists and their groups would result in a disappearance of these superficial differences. —K. L. KAUFMAN, PH.D., Richmond, Virginia.

*Va. Med. Month., June, 1943

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Air-Swallowing; "Gas"

Eighty per cent of patients complaining of stomach and intestinal distress have symptoms of abnormal fullness, gas, and belching. Air-swallowing (aerophagia) is normal whenever food, drink, and saliva are being swallowed. The unnatural introduction into the stomach of air is due to many causes. The infant, breast or bottle fed, takes air in with its feeding. The flighty, nervous, or hysterical individual uses this means in order to impress his friends and for the purpose of creating sympathy. In individuals with "globus hystericus," it is the desire of the patient to push the lump in the throat downward with a greater attempt at swallowing it. The result is a large air-bubble in the stomach, which is later used in an effort to belch. The *vicious circle* is created

which causes a phantom tumor to be sensed. Thus, two methods of introducing air are presented, the effort swallowing and air suction or belching.

Symptoms

Epigastric fullness, pain, dyspnea, palpitation and even premature contractions of the heart are caused by the distension of the stomach with air. Other less direct symptoms may be dizziness, dull headache, numbness, tingling, heartburn and sensation of fullness in the head.

Belching brings temporary but grateful relief, usually for half an hour, then the feeling of "gas on the stomach" returns and with it the persistent belching.

Treatment. Belching is a habit and the treatment for the persistent desire to belch is this: Tell the patient to take five or six deep breaths, instead of belching. Heat should be applied to the epigastrium and sedatives should be given. The patient should be told that the belching is a harmless symptom.—G. HAYNE, M.D. in *Minn. Med.*, Apr. 1943.

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Meat Advice

American habits of choosing, buying, preparing and serving meats have been wasteful of both food value and money. Americans have scorned the animal organs and the cheaper cuts of muscle meat, tasteful and nutritious though these may be. Our people do not use fat meats—on the other hand, they push to buy the cuts which include a large portion of meat and gristle, representing waste. We overcook most of our meats.

We should start at once to use hearts, livers, kidneys, brains, tongues, sweetbreads and meats high in fat. We must protect against waste of the meats we buy through proper refrigeration. We must protect against shrinkage by covering the exposed surface of meats stored in the refrigerator and preparing them promptly, within a few hours, if possible, after purchase.

With the exception of pork, which must be thoroughly cooked for safety, *most fresh meats can be served rarer* than they generally are, with advantages of taste as well of nutrition.—*Ill. Med. J. Apr.*, 1943.

Housewives' Hands Dermatitis

Persistent dermatitis on the hands of housewives may be due to : (1) *ringworm* infections of the feet with an allergic reaction on the hands, (2) soaps, cleansing powders, wools used in knitting, varnishes, finger nail polishes and lacquers, and even cosmetics, (3) an allergic reaction, (4) achlorhydria, (5) vitamin deficiencies, (6) ovarian and thyroid deficiencies, (7) focal infection, (8) psoriasis.

If ringworm infection is suspected, the feet should be carefully examined and the Trichophyton test performed. If the test is negative it shows that the individual does not have ringworm.

If allergy is suspected, ask about migraine, hay fever, exzema, hives and migraine in the individual and his family. The condition in these cases is usually due to foods; one should eliminate milk, wheat, eggs, peas, beans, spinach and chocolate and nuts routinely. Rowe's elimination diets may then be used.

The administration of dilute hydrochloric acid will relieve the dermatitis if achlorhydria is the cause.

Vitamins A and C should be given. If there are any symptoms of ovarian or thyroid deficiency, one may give thyroid extract, with or without estrogenic hormone.

If the dermatitis on the hands or feet is arranged in patterns, either triangular or square, with sharply demarcaeted borders, focal infection should be suspected.—C. C. DENNIE, M.D., in *J. Missouri M. A.*, Mar. 1943

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Breast Tumors Due to Ovarian Tumors

Ovarian tumors may secrete hormones which result in benign tumors, either solid or cystic, of the breast.

A 65 year old woman presented a tumor of the breast which was found to be benign. Pathologic study showed epithelial activity, which is abnormal in women past the menopause. Therefore, a diagnosis of rejuvenation of the ovaries or of a granulosa cell tumor of the ovaries, was made. At a later operation, tumors were removed from both ovaries. The fluid taken from the cystic portions contained estrogenic hormone (as proven by injection into spayed mice).

A 45 year old woman had had four "lumps" removed from both breasts at 3 operations over a period of four years. The lumps proved to be cystic ("abnormal involution"). Both breasts were

shotty, tender and subject to periodic pain, tenseness and tenderness in tune to her menstrual rhythm, which was somewhat irregular. Pelvic examination disclosed a solid tumor, which on removal proved to be an ovarian tumor; the other ovary, also removed, contained many cysts, fluid from which contained estrogenic hormone. No further treatment was needed by the breasts, which gradually shrunk, lost their tenderness and shotty areas.—STANLEY P. REIMANN, M.D., in *Penn. Med. J.*, May, 1943.

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Cooling for Shock

The patient in shock should be kept cool. It has been shown that subnormal temperatures (down to 90° F. rectally) are well tolerated and may be life saving. Subnormal temperatures keep the body metabolism at lower level and permit the return to consciousness with less oxygen consumption.—R. K. BROWN, M.D., in *J.A.M.A.A.*, Mar. 27, 1943.

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Short Wave Therapy Technic

Principle: Short wave diathermy consists in the application to the patient of a current which is oscillating with tremendous rapidity, and which has the property of healing the tissues it traverses.

It enables us to increase at will the circulation of any part of the body. *Moderate heat is all that is required in most cases,* as the local temperature need not be very high before the maximum effect is obtained.

Technic: Two pads are used, with the affected part of the body placed accurately between; they should be held *firmly* in position with an elastic band or by a bracket. (See illustration.)

Variations in progress: Improvement may begin immediately after the first application and increase steadily. A slight adverse reaction may follow the first treatment, and is then followed by improvement. Other patients will apparently not respond during a course of treatment, but will begin to improve dramatically afterwards.

Dosage: No set scale of dose can be applied, because of differences in patients and lesions. A test dose is advocated, for the first treatment. A very small dose is given and the patient told to return in 24 hours before any further therapy is given. Practically no sensation of heat should be experienced during the first treatment. The dosage may then be gradually increased, if no unpleasant symptoms have resulted, and the length of treatment gradually increased.

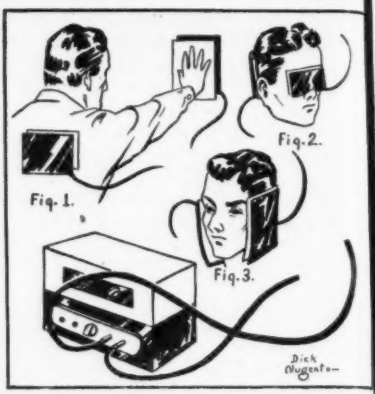

Fig. 1. Position for short wave therapy of arm and shoulder conditions.

Fig. 2. Application of electrodes for treatment of eye and sinus disease.

Fig. 3. Technic for therapy of ear and throat disease.

Clothes, bandages, splints and casts need not be removed. The patient should experience only a sensation of gentle penetrating heat; *he should be told that a temporary increase in symptoms may take place after any treatment,* but that it is not important (except as a sign not to increase the length or amount of current for the next several treatments).

Conditions to be treated: Sinusitis, pharyngitis, certain cases of hay fever, boils and carbuncles, muscular injuries and myositis, periostitis and osteomyelitis, fractures, arthritis and gout, bursitis, paronychia, neuralgic eye pain and conjunctivitis (even glaucoma has been benefited in a few cases), low back pain and sacro-iliac pain, deafness due to catarrhal swelling of one or both Eustachian tubes, postnasal drip, laryngitis, quinsy, bronchitis, pneumonia and pleurisy, certain cases of asthma, lung abscess, empymema and bronchiectasis, abdominal pain due to certain types of gall bladder disease, peptic ulcer pain, inflammations of the uterus and tubes, neuritis and neuralgia, and tonsillitis.

Neurasthenia, general neurosis, sleeplessness and anorexia may be benefited by weekly treatments applied to the head and upper abdomen. Eczema and dermatitis respond to the increased circulation.—K. R. SPEEDING, M.B., in *Brit. J. Phys. Med.*, Apr. 1943.

Treatment of Amenorrhea With Gonadotropin

Gonad stimulating preparations are of two types: (1) Serum gonadotropin, prepared from the blood serum of pregnant mares and; (2) chorionic gonadotropin, obtained from pregnant women's urine.

Dosage: An intramuscular injection of 5,000 International units of serum gonadotropin is given daily for 5 days, followed by 1,500 units of chorionic gonadotropin daily for 3 days. Menstruation appears within 10 days, if the patient reacts to such therapy. The great majority of patients with secondary amenorrhea and some of those with primary amenorrhea respond well, menstruation being permanently reestablished and rarely, pregnancy occurring.

Complications: Tenderness, pain and swelling of the ovaries occur in a few cases. Fever of 100 to 102° F. may follow the injections.—E. RYDBERG, M.D. in *J.A.M.A.*, Apr. 3, 1943.

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Modern Anesthesia

The use of *continuous spinal anesthesia*, as developed by *Lemmon*, has made it possible to carry out operations by using procaine only. (Procaine is much less toxic than other medications used to produce anesthesia, and may be used in poor risk cases.) *Ether* (diethyl ether) is the agent of last resort if other agents fail to bring about sufficiently deep anesthesia and relaxation for the purpose at hand. It should be given by the *open drop* method, as difficulties occur in giving it through a gas machine. Combinations of several anesthetic agents, such as intravenous and spinal anesthesia or intravenous and local anesthesia, are valuable. — J. S. LUNDY, M.D. in *Proc. May Clin.* May 5, 1943.

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Nail Puncture Wounds

Tetanus has not occurred in 3,400 cases of nail puncture wounds of the foot (presented by Dolan before the American Association for the Surgery of Trauma) in which (1) a clean gauze dry gauze dressing was applied to the wound at once, and (2) the skin edges were excised, as soon as possible.

The latter step is taken because nails push in the skin, then are withdrawn leaving a sealed wound which cannot drain and in which organisms can grow. Another industrial surgeon feels that tetanus antitoxin is only necessary if wounds are contaminated by excreta or where the wounds occur on the street or stable —H. W. MEYERDING, M.D. in *Minn. Med.*, Aug. 1943.

On the sole of the foot, do not attempt to raise a wheal with procaine solution as the skin is so tough that such a procedure is painful. After the wound is well cleaned with soap and water, inject the procaine solution (1% with a drop of epinephrine or adrenalin) into the edges of the wound.—Ed.)

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Vitamin A for Ichthyosis

The use of 60,000 to 200,000 international units of Vitamin A daily, over a period of several months, resulted in marked improvement in patients with ichthyosis. Cracks and fissures disappeared; pruritis was much diminished. Improvement was progressive as long as the vitamin A was taken; gradual regression occurred when the vitamin was stopped. Ichthyotic patients often have an impairment of vision at night (dark adaptation), a symptom of vitamin A deficiency.—H. G. RAPAPORT M.D. in & *J. Ped.*, Dec. 1942.

(Parke-Davis produces an inexpensive form of concentrated vitamin A (Anatola) with 33,333 units in each capsule.—ED.)

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Differential Diagnosis of Rheumatic Fever

These signs and symptoms should make one suspect the presence of active rheumatic fever: "fever," "Pains and weakness of the legs," "anemia," "arthritis of several joints," "nervousness," "purposeless movements," "heart murmur or leakage," "swollen, painful joints" and "abdominal pain and fever." —ARILD HANSEN, M.D.

Nose bleed, arthritis, leg pains, red skin eruptions (erythema annulare, erythema nodosum, erythema multiforme), chorea, stiff neck and pains in the chest, precordium or abdomen are outstanding symptoms of acute rheumatic fever. —S. P. DITKOWSKY, M.D.

Abdominal pain, vomiting and abdominal tenderness may mark the onset of rheumatic fever. Fever is usually present and other signs of acute rheumatic fever may occur (swelling of the joints, leukocytosis, chorea, cardiac murmur, pains in extremities). Appendicitis is frequently diagnosed. In the *differential diag-*

nosis involving abdominal pain in children of school age, rheumatic fever must be considered.—ARILD E. AHSEN, M.D., in *J.A.M.A.*, Mar. 27, 1943.

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Sulfadiazine for Infections

Sulfadiazine is effective against many infections. *Dosage:* 2 Gm. as initial dose, followed by 1 Gm. every four hours for 24 hours, and then 1 Gm. every six hours (four times daily) thereafter. This table shows the results obtained:

Exercises for Asthma

The difficult breathing of asthma differs from all other forms of difficult breathing in that it is mainly expiratory in character, and the lungs therefore become overdistended.

Physical exercises will restore the lungs and chest to their normal size. "Physical Exercises for Asthma," 4th edition, revised, as approved by the Asthma Research Council of England, has just been published (H. K. Lewis & Co. Ltd., price twenty-five cents). — *Brit. J. Phys. Med.*, May 1943.

SULFADIAZINE FOR INFECTIONS

	CONDITION	EFFECT		
		Possible	Good	Poor
1.	Pemphigus vulgaris			X
2.	Pemphigus vulgaris		X	
3.	Actinomycosis—jaw	X		
4.	Actinomycosis—neck	X		
5.	Subacute bacterial endocarditis			
6.	Pneumococcus VI			X
7.	Streptococcus viridans		X	
8.	with rheumatic heart		X	
9.	with congenital heart			X
10.	Rheumatic fever		X	
11.	Chronic ulcerative colitis		X	
12.	with rectal abscess		X	
13.	Chronic multiple (Staph.) infections			X
14.	Cellulitis of the jaw—postoperative	X		
15.	—preoperative	X		
16.	Carbuncle and furunculosis	X		
17.	Monilia pneumonitis with cavitation	X		
18.	Putrid empyema and pneumonitis			X
19.	Subacute bronchiectasis and pneumonitis	X		
20.	Unresolved pneumonia		X	
21.	with lymphosarcoma		X	
22.	with atelectasis			X
23.	Military abscesses of lung	X		
24.	Tracheotomy cellulitis			X
25.	Chronic bronchitis—Pneumococcus III			X
26.	—Pneumococcus XIII			X
27.	Bronchial pneumonia	X		
28.	with pleurisy	X		
29.	Lobar pneumonia (Type I) (laboratory infection)	X		
30.	Chronic pneumonitis with congenital atelectasis			X
31.	Postoperative pericardial empyema (Staph.)			X
32.	Post-pneumonectomy empyema		X	
33.	Post-thoracoplasty wound infection			
34.	Staph. aureus			X
35.	Staph. aureus		X	
36.	Staph. aureus			X
37.	prophylaxis		X	
38.	extrafascial empyema	X		
39.	Hyperplastic laryngitis			X
40.	Secondary infection in tuberculosis knee			
41.	Osteomyelitis of the foot			X

J. B. BINGHAM, M.D., in *Wis. Med. J.*, Mar., 1943

Treatment of Colles Fracture

Under anesthesia, the hand is grasped and "shaken" as in shaking hands while strong traction is made, so that all fragments are loosened completely. Then, while the traction is maintained, further moulding of the fragments between thumb and fingers is carried out. The hand is then held in full pronation, moderate but not forced flexion, with deviation of the hand to the ulnar side. A circular plaster cast is then moulded carefully to the arm from the elbow joint to the *base* of the fingers.—C. C. CHATTERTON, M.D., in *Minn. Med.*, Aug. 1943.

(The injection at 10 to 15 cc. of 1 percent procaine solution into the point of fracture provides good anesthesia.—Ed.)

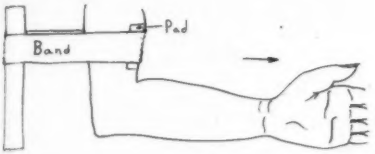

Fig. 1. Strong traction is exerted on the hand. A band around the upper arm, which is protected by a pad on the flexor surface, may be attached to a pipe or other fixed object, thus giving steady counteraction and obviating the need of another assistant.

Fig. 2. The patient's hand is grasped as in shaking a hand. While strong traction is employed, the fragments are loosened.

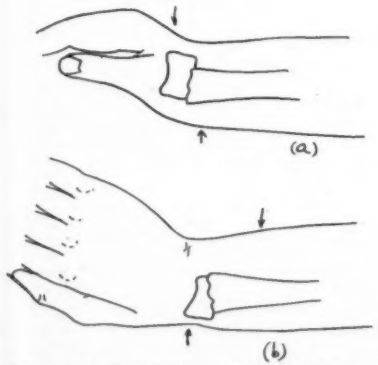

Fig. 3. The fragments are moulded between the thumb and fingers, so that the "silver-fork deformity" (a) is reduced and (b) the fragment is moved toward the ulnar side of the wrist (away from the fracture).

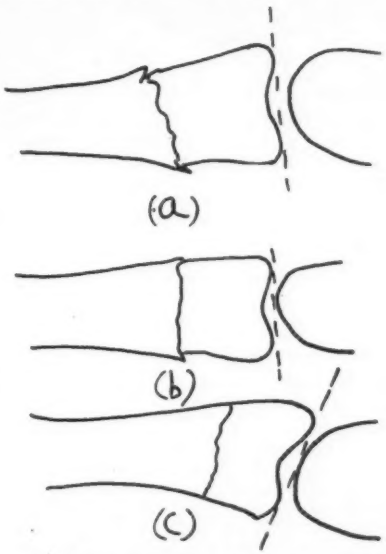

Fig. 4. The fragment of the radius tends to tilt backwards in displaced (a) and impacted (b) Colles fractures. The latter fracture is often "let alone" because the position, especially on the antero-posterior x-ray, seems good. A permanent loss of some wrist function may be expected unless the normal forward position (c) is restored.—Ed.

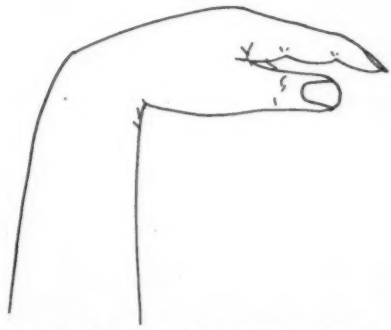

Fig. 5. The test of full correction. The hand drops forward, without force, into normal position of full flexion (although it is best not to splint it in such extreme flexion because of possible stiffness later).

THUMBNAIL THERAPEUTICS

X-Raying the Tuberculin Positive

If all patients who have positive tuberculin tests are x-rayed, the tragic onset of active, advanced tuberculosis will be prevented. *Roentgen films usually show a beginning lesion two and a half years before clinical symptoms are present.*—J. A. MYERS, M.D. *before the Linn County Medical Society*, Mar. 12, 1943 (Cedar Rapids, Iowa).

Stilbestrol in Premature Menopause

• Young women with menstrual irregularities and symptoms of premature menopause will be relieved by the use of stilbestrol during the week preceding the expected onset of menstruation. The initial dosage is 1 mg. three times daily, which is increased if relief does not follow. — C. COLLINS, M.D. in *Tri-State Med. J.*, Jan. 1943.

Intractable Peptic Ulcer

• The chronic peptic ulcer patient may be relieved of night distress by (1) eating a liberal meal at 7 or 8 A.M., consisting of coffee or tea, toast, fresh fruit and meat, (2) eating a lunch at 12 consisting of light protein, either meat, fish, eggs or cream cheese, pureed vegetables, stewed or fresh fruit and tea, (3) avoiding an evening meal, with its consequent outpouring of acid during the night. — P. S. CAMPICHE, M.D. in *Am. J. Dig. Dis.*, May 1943.
—*E.E.N.T.M.*, May 1943.

Corneal Ulcers

• Injections of ascorbic acid (vitamin C) have marked therapeutic value in the treatment of corneal ulcers, superficial inflammation (keratitis), and chronic corneal opacities.—*E.E.N.T.M.*, Mar. 1943.

Fatigue

• The frequent administration of carbohydrate containing foods and the daily administration of atropine (to prevent vagal stimulation of the pancreas and resultant hypoglcyemia) relieves many fatigued persons. Atropine should be given in doses of 1/500 to 1/100 gr. three times daily, as tolerated by the individual.—*Am. J. Dig. Dis.*, Jan. 1943.

Treatment of Trachoma

• The removal of the follicles, in certain cases of trachoma, by suction is much less traumatizing than by expression.—*E.E.N.T.M.*, Mar. 1943.

Routine Catheterization in Obstetrics

• The bladder should be emptied by catheter before any type of delivery. A separated placenta may be retained in the uterus because of a distended bladder. Those patients with continous caudal anesthesia should be catheterized at 8 hour intervals to avoid distention of the bladder.—ARTHUR BAPTITISTI, M.D. in *Urol. & Cut. Rev.*, Mar. 1943.

Tinnitus

• Procaine hydrochloride, given intravenously, is effective in reducing the intensity of continuous noise in the ear in most cases associated with normal hearing, deafness of the inner ear, otosclerosis.—*E.E.N.T.M.*, June 1943.

Pelvic Mass Following Delivery

• Following delivery a mass may be noted in the pelvis or perineum. Rupture of a vein during delivery and hematoma formation accounts for many of these masses. The patient should be observed monthly; the mass should gradually decrease in size, ultimately disappearing with residual induration.—*J. A. M. A.*, June 5, 1943.

DIAGNOSTIC POINTERS

Cancer of Mouth

• In about 40 to 50 per cent of all oral cases, syphilis is a concomitant of cancer and often its ulcer covers the underlying malignant lesion. When a lesion in the mouth fails to disappear with antisyphilitic treatment, malignant disease should be suspected. Syphilis sometimes appears as a primary chancre, but more frequently as a gumma. It is a painless lesion, not usually accompanied by local lymphatic gland involvement. Antisyphilitic therapy often alleviates this condition, especially if cancer is not associated with it.—I. KAPLAN, M.D., in *Med. World* (London), Oct. 22, 1943.

Tuberculosis

• The persistent presence of tubercle bacilli in the sputum, in the presence of a tuberculous parenchymal lesion, is to me an indication for early collapse therapy regardless of clinical symptoms, physical signs, or benign x-ray changes. —ARTHUR REST, M.D. in *Rocky Mt. Med. J.*, Dec. 1943.

Gain in Weight and Malignancy

• The fact that a patient gains weight should not rule out cancer. I have seen patients gain from 45 to 60 pounds after laparotomy, yet eventually die from the malignancy. In one case, proven microscopically, the patient was alive and clinically well for four years, then suddenly went down hill and died.—WALTER ALVAREZ, M.D., in *Proc. Mayo Clinic*, Aug. 25, 1943.

• "When considering an operation," Dr. Robert Lovett has said, "you should ask yourself three questions: 'What am I going to do?' 'How am I going to do it?' 'Is it worth doing?'". —*Hawaii Med. J.*, Feb., 1943.

Thyroid Extract: Gynecological Uses

• Hypothyroidism is a common cause of sterilty, miscarriage, premature labor, death of the fetus, amenorrhea, and menorrhagia.—C. J. BAUMGARTNER, M.D. in *Calif. & West. Med.*, Nov. 1942.

(Thyroid extract is the cheapest, the most effective and the safest hormone to use in treatment of gynecologic patients.—ED.)

Diagnosis of Ectopic Pregnancy

• The most common and dependable symptom of ectopic pregnancy is *lower abdominal pain*. The history of a late, missed or abnormal menstrual period followed by pain and passage of *dark blood* (as contrasted to the red blood from a miscarriage) is almost diagnostic of ectopic pregnancy.—F. S. JOHNS, M.D. in *Va. Med. M.*, Aug. 1943.

Polycythemia and Neurologic Signs

• Neurologic signs and symptoms of polycythemia vera may confuse the diagnostic picture. Headache is a common symptom, as is vertigo. "Neurosis" and exhaustion are frequently diagnosed. "Epileptic attacks," loss of consciousness, insomnia, excitability, cerebral hemorrhage and aphasia are other signs and symptoms which may occur in polycythemia.—H. Z. GIFFIN, M.D. in *Proc. Mayo Clin.*, Aug. 25, 1943.

Gastrointestinal Symptoms from Malaria

• Vomiting, diarrhea and abdominal pain may be caused by malaria. Patients have been operated upon for suspected intestinal obstruction. Diarrhea may be misleading in patients recently back from the tropics, as bacillary and amebic dysentery must be excluded, but malaria must be remembered.—H. MELENEY, M. D. in *J.A.M.A.*, Jan. 8, 1944.

NEW BOOKS

Any book reviewed in these columns will be procured for our readers if the order, addressed to CLINICAL MEDICINE, Waukegan, Ill., is accompanied by a check for the published price of the book.

Some will read old books, as if there were no valuable truths to be discovered in modern publications.
D'ISRAELI

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ATLAS OF OBSTETRIC TECHNIC

Titus

ALAS OF OBSTETRIC TECHNIC. *By Paul Titus, Obstetrician and Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; Secretary, American Board of Obstetrics and Gynecology. Illustrations by E. M. Shackelford, Medical Illustrator, Oliver Memorial Research Foundation, St. Margaret Memorial Hospital, Pittsburgh. St. Louis: The C. V. Mosby Company. 1943. Price. $7.00.*

This beautiful atlas shows in step-by-step sketches, the exact technic of vaginal and abdominal procedures needed in obstetrical care, including: normal delivery, forceps delivery, version, breech extraction, management of birth canal injuries, cesarean section (*all* methods), mutilating operations, placental operations, and also postpartum procedures (cauterizing the cervix, sterilization, breast abscess, simple method for cervical anesthesia), treatment of sterility, major and minor operations during pregnancy, treatment of abortions and ectopic pregnancy, induction of labor and enlargment of the cervical orifice.

This book will be a god send to any one who wishes to review his technic and to bring it up to date. Medical students will find that it is complete, from the first sketches showing preparations, draping and cleansing the patient for a normal delivery, through pelvimetry and x-ray studies. A separate chapter is devoted to sterility studies.

The sketches are accurate and of definite teaching value.

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1944 DAILY LOG FOR PHYSICIANS

Colwell

DAILY LOG FOR PHYSICIANS, 1944. *John B. Colwell. Colwell Publishing Company, Champaign, Illinois. Price. $6.00, postpaid.*

Through the years, the Daily Log has been used by thousands of physicians to keep a quick, accurate record of their office accounts.

This new edition contains pay-as-you-go tax forms, and a comparative income schedule that will aid in estimating 1944 income. Facts about professional and outside income from 1943 can be assembled and revision made for the new year on the basis of these figures. Once the 1944 estimate is established, taxes are determined by using the table or schedule furnished by the treasury department. Quarterly payments and withholdings are noted on tax form two, where they become part of the permanent records. A new form, for non-professional deductions will contain income tax data on deductible expenses such as taxes on living quarters.

This Log has been published for 16 years. Each year's edition is changed to meet the conditions of the day.

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SPECIALTIES IN MEDICAL PRACTICE

Allen

SPECIALTIES IN MEDICAL PRACTICE. *Edited by Edgar Van Nuys Allen, M. D., Division of Medicine Mayo Clinic; Associate Professor of Medicine, the Mayo Foundation of Medical Education and Research, Graduate School, University of Minnesota. New York city: Thomas Nelson & Sons.*

The 1943 renewal sheets for the loose leaf 2 volume edition of "Specialities in Medical Practice" are of keen interest.

W. Kenneth Jennings of Northwestern contributes many pages (109) and illustrations on minor surgery and first aid, which covers some common conditions seen in the office and hospital. Dr. Don King's revision of orthopedic topics presents detailed illustrations showing methods of management of bunions, hammer toes and other frequently encountered lesions.

A larger, revised index is furnished, with new front pages, two new color plates and additional material on ophthalmology (Harry S. Gradle), ear, nose and throat (Lawrence Boies), neurology (Henry Viets), vitamins and vitamin deficiency diseases (Dwight L. Wilbur), allergy (Frank Simon), obstetrics and gynecology (G. D. Royston), urology (John Emmett) and dermatology and syphilis (Lomholt and Miller).

In this manner, one can refer to a single set of books and have *all* the information desired to date. It is said that every book is a year behind by the time it is published. The loose leaf method avoids this lapse in making up a complete new book, avoids the referring to a number of texts and saves expense.

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MALIGNANT TUMORS

Stern and Willheim

THE BIOCHEMISTRY OF MALIGNANT TUMORS. *By Kurt Stern, M.D. Formerly Research Associate of University of Vienna, New York City and Robert Willheim, M.D., Professor, University Of Philippines, Manila. Brooklyn, New York: Reference Press. 1943. Price $12.00.*

The publishers and authors are to be congratulated on carrying out a difficult, thankless task. The newer studies of biochemical aspects of malignant tumors are reviewed, and whenever differences have appeared, these differences have been at least partially reconciled.

The viewpoint of inorganic chemistry is first approached. Then physical chemistry, enzymes-nutrition, and vitamins, metabolism, endocrine glands and their hormones, immunology, biochemical aspects of tumor origin and tumor growth, and chemical and biological tumor diagnostics are discussed.

The clinician will be most interested in the final chapter concerning diagnosis of tumors, and the authors opinion that a combination of several tests will probably be most effective.

The literature up to a recent time has been fairly thoroughly digested and analyzed. The book is a welcome addition to our knowledge.